Front Range FLU SHOTS LLC
ON-SITE IMMUNIZATIONS

CONSENT FOR TREATMENT INFLUENZA SHOT

✓ Please make checks payable to Front Range Flu Shots, LLC *or* FRFS.

Please Print

Last Name **First Name** **Middle Initial**

Date of Birth	**MM**	**DD**	**YY**	**Age**	☐ **Male** ☐ **Female**	**Phone Number ( )**

Address: Street **City** **State** **Zip**

Insurance Billing: Please answer all questions below. Note*:* Medicare Part B will pay for your flu shot only if it is your primary insurance.

1.) I have Medicare and an additional insurance plan: ☐ Yes ☐ No
2.) Medicare Part B is my primary insurance plan: ☐ Yes ☐ No
3.) Medicare members enrolled in a HMO may not be covered by insurance. Do you have HMO insurance? ☐ Yes ☐ No
4.) Kaiser members must pay by cash or check. Do you have Kaiser insurance? ☐ Yes ☐ No

Please provide all information that applies:

Print Name exactly as it appears on insurance card:_____

☐ Medicare Advantage Plan: Member Id # _____

_____ Medical Claim Address: _____

☐ Medicare Part B Member Id # # ___ ___ ___ - ___ ___ - ___ ___ ___ ___ letter(s) ___ ___

☐ Railroad Medicare Part B Member Id # letter(s) ___ ___ # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Cofinity Co pay due at time of service:$_____ Member Id # _____

☐ Douglas County School District Cigna Member Id # 779 ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ Rocky Mountain Health Plans Member Id # ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___

Please answer each of the following questions and sign and date below:

1. Have you ever had a flu immunization before? Yes No
2. Have you ever had an adverse reaction to a flu shot? Yes No
3. Do you have a history of hypersensitivity (allergy) to chicken eggs or egg protein? Yes No
4. Have you ever had an allergic reaction to any component of the vaccine, including thimerosal? Yes No
   Describe:_____
5. Do you currently have a fever, or moderate or severe acute illness with or without fever? Yes No
6. Do you have a history of Guillain-Barre Syndrome (a severe paralytic disease, also called GBS)? Yes No
7. Have you ever had a bad reaction to any other vaccine? Describe: _____ Yes No

★ I have received the current *Inactivated Influenza Vaccine Information Statement*. I have read or have had explained to me the information. I have had an opportunity to review *FRFS's Notice of Privacy Practices* and am aware that I can request a copy. I have had a chance to ask questions and, if any, they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and I ask that the vaccine be given to me or to the person named for whom I am authorized to make this request. I agree that Front Range Flu Shots, LLC shall have no responsibility or liability if I or the named person contract influenza or any other respiratory diseases or suffer any adverse reaction following administration of the vaccine.

★ I understand that I am responsible for payment to Front Range Flu Shots, LLC if vaccination is not fully covered by insurance company.

★ I understand there is a $25 fee for returned checks.

Signature of Responsible Person: _____ **Date:** _____

Insurance Coding Information		**Do not write below this line.**	
Federal Tax ID:	743077363	**INFLUENZA VACCINE**	
Service Location:	11	Injection site:	Nurse's Initials _____
Diagnosis Code:	V04.81	____0.50 ml Left Deltoid	Date _____
Procedure Code: Q2035 Afluria / Q2036 Flulaval / Q2037 Fluvirin / Q2038 Fluzone / 90662 Fluzone HD	90658	____0.50 ml Right Deltoid	Mfg *(Circle one)* Sanofi / Novartis / GSK
Administration Code:	G0008	__0.50 ml Left Vastus Lateralis	
RMHP Administration Code:	90471	__0.50 ml Right Vastus Lateralis	Lot # _____
Charge:	$		
Clinic Location:			

Front Range Flu Shots, LLC ▲ P.O. Box 1093, Littleton, CO 80160-1093 ▲ 303-797-3396 08-11

MED ADV / MC / RRMC / Cofinity_____ / DCSD / RMHP / HD / Comp / Invoice / Check _____ / Cash _____